Setting up regional audit in genitourinary medicine and HIV: The South East Thames experience

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Abstract

Audit at regional level is a useful complement to local audit, especially in small specialties. Regional audit can reduce professional isolation and lead to the development of uniformly high standards in the care given by a variety of providers. The development of regional audit in genitourinary medicine in South East Thames (UK), and of HIV medicine in South Thames, is described. Meetings are held quarterly, and concentrate on standard setting and development of guidelines. Information about the practice of individual units is collected by questionnaire, the results presented, and guidelines developed. Participation in completing questionnaires and attending the meetings is good. Regional guidelines in eleven topics have been produced, and methods of auditing changes in practice are now being assessed. A regional common data-set is being developed to assist in the audit process.

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Introduction

WHY DO REGIONAL AUDIT?

Audit at regional level is particularly relevant to both genitourinary medicine (GUM) and HIV medicine. Genitourinary medicine is a small specialty with limited opportunities for peer review outside the teaching centres; a minority of district general hospitals have more than one genitourinary physician and in many cases a consultant will run clinics in two or more hospitals. Pressure of work and difficulties in obtaining locum cover for study leave or to attend meetings contribute to professional isolation. Joining with other local clinics is therefore necessary to provide sufficient diversity of experience and opinion.[1 2]

Two features of GUM are, however, especially helpful in the audit process. Firstly, that for reasons of confidentiality, departments keep their own patients' notes so these are readily accessible. Secondly, that a national system of diagnostic codes has been used for many years. As all clinics have a statutory duty to keep and submit figures for numbers of patients seen and their diagnoses, coding is given a high priority.

Human immunodeficiency virus (HIV) medicine is a new specialty which has evolved differently in various areas in response to local needs. Over the country most patients are cared for by genitourinary physicians, but specialists in chest medicine, haematology, and infectious diseases are also involved. There is also considerable variation in patterns of management, which sometimes represents a balance between local interest in HIV and fear of infection; for example in some districts it has been difficult to obtain certain services such as endoscopy on HIV positive patients. HIV medicine is developing rapidly, and although there is now a vast body of research data on HIV infection,[3] there is comparatively little agreed or published on "good practice".

These factors can result in major disparities in care between the large urban centres, with the expertise gained and facilities developed as a result of seeing hundreds of patients, and other hospitals whose HIV patients are numbered in single figures. Audit at regional level can encourage the development of uniformly high standards in the care given by a variety of providers. Regional audit should not replace local audit but instead complement it; there will still be areas best addressed in detail by individual units.

Role of regional audit

The aims of regional audit and district audit differ; whereas it may be appropriate to do a great deal of work locally in order to investigate a specific topic fully and make necessary changes, there is seldom an indication to carry out identical labour-intensive investigations in all districts within a region. Instead a realistic initial aim is to concentrate on setting and agreeing regional management guidelines and standards for effective practice,[4] and then if requested to provide help in a district when problems are identified.

In order to carry out regional audit effectively it is essential that comparable data are obtained from all districts. The required data set must be simple, and concentrate on readily available information, otherwise it becomes very difficult for small units to participate. Ideally as many units as possible should participate. This strategy means concentrating on information about "process", at least initially. Information on specific outcomes has often already been researched and published, and this can be taken into account when setting standards. Where further information is needed audit or research projects can be set up in one or more districts.

In practice the way in which this format was developed in our region was by arranging

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quarterly meetings in each sub-specialty. In genitourinary medicine these were arranged to precede our Specialty Sub-Committee (SSC) meetings, which are well attended by the consultants of South East Thames.

In HIV medicine audit was incorporated into the evening meetings of the South Thames HIV Physicians Group, which are attended by consultants and doctors in training working in relevant specialties in both South East and South West Thames. This group was originally formed six years ago as the South East Thames HIV Physicians Group, which started as a forum for case presentations and discussion by HIV physicians from throughout the region. The meetings proved popular, and the group expanded to become the South Thames HIV Physicians Group as a result of physicians from South West Thames asking if they could also attend.

Funding for both audit groups was obtained from regional audit funds and regional HIV funds to employ a full-time audit assistant to co-ordinate the work, and to cover the running costs of the project.

The format of both meetings is similar. The topic for each meeting is decided at the one before, and we then develop and distribute standardised questionnaires for collecting information. Initially these were sent out in draft form for comments, but we found that inevitably a few people would complete and return the drafts by mistake, and so it was agreed to stop this practice. The forms request some demographic information, for example the number of patients diagnosed to have the condition under review during one quarter, but otherwise concentrate on practice, in particular access to and use of diagnostic tests and treatment.

At the next meeting the results are presented and discussed with input from one or more invited "guest experts", who advise using their understanding of good practice backed by relevant research findings. The guest experts are usually academic clinicians or laboratory specialists. Draft guidelines are then drawn up and standards set, and these sent out with the next mailshot together with minutes of the meeting. Comments on the guidelines are invited, and the guidelines then amended as necessary and adopted at the next meeting.

Progress so far

The format outlined was set up in early 1992, and a variety of topics reviewed; these have been mainly medical but have included other topical areas where regional agreement would be beneficial. In genitourinary medicine these have included the management of genital *Herpes simplex*, the use of acyclovir for genital herpes in pregnancy, Hepatitis B screening and vaccination, the management of syphilis, the way in which attendances and diagnoses are recorded, communications with general practitioners, the management of chlamydia infection, and the management of gonorrhoea. In the HIV meetings we have covered the management of *Pneumocystis carinii* infection, diarrhoea, and toxoplasmosis, medical support for benefits, anti-viral treatment, and the management of *Mycobacterium avium* complex.

After the audit meetings had been running for a year in the format described we reviewed our activity. Initially topics had been selected because individual districts had a particular interest or because the subjects were topical, and we felt that more objective criteria were needed as part of a long-term strategy which would both incorporate new topics and "close the loop" on those already covered.

We also needed to determine the best way of auditing the effect of agreeing guidelines and compliance with standards at the regional level. A practical difficulty was that only some of the region's GUM departments were able to carry out detailed case note audits, as staff shortages precluded this in the smaller clinics. We therefore decided to begin by the audit assistant travelling to a sample of clinics to carry out a pilot case note audit on the management of genital *Herpes simplex*, which was the first subject for which guidelines had been agreed. Reservations were expressed about the audit assistant visiting clinics and examining notes, but these appeared to be countered by setting clear boundaries for this activity and giving a guarantee of confidentiality.

The three clinics in the pilot audit were representative of the range of clinics within the region, comprising a large London teaching hospital department and one medium sized clinic and one single handed clinic in towns outside London. The audit assistant was made welcome in each.

The method used to assess compliance with the guidelines was to measure whether prescriptions and other decisions recorded in the notes complied with, or were close to, the guidelines. Compliance with the guidelines was found in 87% of decisions recorded, with most of the other 13% due to information not being recorded or not recorded in comparable form. The format of notes and type of information recorded will now be a subject for a future audit. Arrangements have now been made for the audit assistant to visit three other clinics to carry out case note audit on the next area for which guidelines were agreed.

Lessons learned to date

Generally the format outlined works well in terms of forms being completed and returned and in attendances at audit meetings. In S E Thames there are 20 genitourinary medicine clinics. The number of consultants in the region has increased from 14 to 16 over the period studied; the number of questionnaires completed for each topic has risen from 4 to a mean of 12 (75%).

There are now 51 people on the South Thames HIV Physicians Group mailing list, of whom 11 wish to receive information only. Thirty of the other 40 are consultants, of whom 23 (76%) are GU physicians, with the remainder working in thoracic medicine, infectious diseases, haematology, or dentistry.

Completion of questionnaires and attendances at the meetings vary according to the topic under discussion. In the HIV group initially seven of the 13 doctors attending completed questionnaires; in 1993 this number rose to a mean of 19/40 (48%) clinicians completing questionnaires and 20 (50%) attending each meeting.

In common with others, we have found that our questionnaires have improved with experience.[5] Initially we made them too long and too complicated, resulting in time consuming data analysis, some unclear results, and meetings that were too long to maintain interest. Wherever possible we now ask questions which have a "yes" or "no" answer or one of a short range of defined options. Compliance in returning questionnaires has also been helped by limiting them to three sides (A4) and 15 questions, and stating clearly on them where they should be returned to, and by what date. An encouraging telephone call from the audit assistant shortly after the deadline also improves the response rate.

We now include an evaluation form with each mailshot. This is optional, and can be sent in either with the audit questionnaire or separately and anonymously. The aim is to identify problems with questionnaires, the format of meetings, or the general organisation. To date 40 forms have been returned, and none expressed any requests for change.

Drawing together doctors from many different units often highlights considerable variation in management practices, and results in lively discussion with inevitable constraints on time. Experience sharing has proved to be essential in establishing the groups' ownership of the guidelines developed.[6 7] Agreement on guidelines and standards has been relatively easy to achieve when good research data exist, but can otherwise be difficult and demonstrate the need for such research to be done. Sometimes additional input from external sources is useful; for example acyclovir has a role in pregnancy but is not licensed for such use, and our guidelines on the topic incorporated advice from the defence unions on decision-making and documentation.

The future

At present few health care workers other than doctors are involved in the meetings. We felt that we needed to establish a firm base in purely medical audit initially, especially considering the logistics of getting so many doctors together and then attempting to achieve agreement on guidelines and standards. For certain topics we have invited other health care workers to contribute. This has been successful, and we plan to move towards multidisciplinary meetings whenever a relevant topic is to be discussed.

As the GUM audit meetings were arranged to precede those of the SSC, only consultants attended. We hope now to include doctors in training by rearranging the meetings to precede those of the Association of Genitourinary Medicine, thereby increasing the number of potential participants from 16 to 39.

The regional common data-set

For the longer term, we are devising a regional common data-set so that all clinics will collect the same information routinely on all patients seen. This will be used for audit purposes, but also assist in providing the information increasingly required by purchasers. This should allow regionwide audit over time against the standards we have established.

Our regional common data-set will include district of residence, demographic and epidemiological information and, for both GUM and HIV, management, diagnosis, investigations and results, treatments and case management, and their outcomes.

The task we set ourselves was to identify the minimum, simplest and most readily available data necessary to support audit. Although most GUM departments either have or are acquiring computers on which to store patient information, the systems vary, and so the data-set needs to be practicable for any computerised system—or indeed a manual one. Agreement about what information to keep for audit is also proving to be essential support for any consultant considering computerising the clinic records or establishing links with larger hospital systems.

Conclusions

Our experience shows that for small specialties like GUM or HIV, regional audit can relieve individual small units of the difficulties and duplication of standard setting, and provide support for the audit process. There is still much work to be done with regard to auditing changes in practice and outcome as a result of developing guidelines and setting standards, and we hope that the introduction of the regional common data set will ease this process. Most clinics in the region are now becoming computerised, and ensuring that compatible information is collected by each system will mean that more detailed regionwide audit will become feasible. This could become an economical and efficient way for all units to participate fully in audit.

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Summary of regional guidelines for the management of genital herpes

(1) Drug treatment is of limited benefit in the overall long-term management of patients with genital herpes. Early counselling, education and support are essential adjuncts in preventing long-term morbidity.

(2) Confirm the diagnosis by viral culture but give treatment immediately on clinical grounds.

(3) For severe *initial* episodes, offer oral acyclovir 200mg 5x a day for 5 days. For men with mild symptoms and women whose lesions are healing, saline bathing may be sufficient.

(4) For *recurrent* episodes, advise saline bathing. If the recurrences are severe, however, a supply of oral acyclovir can, after careful consideration, be offered to the patient to use immediately symptoms develop.

(5) *Prophylaxis* with oral acyclovir can be considered for patients having had at least six recurrences a year, with significant morbidity. This may be for a special event or to give respite from the frequency and severity of attacks. Agree a finite treatment plan with the patient at the outset. Begin with 200mg qid for 2 months, and follow up regularly, titrating the dose against the symptoms.